



Department of Medical Assistance Services
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Richmond, Virginia 23219

<http://www.dmas.virginia.gov>

MEDICAID MEMO

TO: All Medicaid Service Providers

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 8/14/18

SUBJECT: Update to Appeal Settlement Process

This memorandum (which supersedes the memo issued on January 10, 2018, titled, “Informal Appeal Settlement Process”) is a REVISION to the previous memo.

The purpose of this memorandum is to provide an update to the procedures for submitting settlement requests during the provider appeal process.

The 2018 Appropriations Act, Item 303(V)(2), states that DMAS and the appealing provider “may jointly agree to stay the deadline for the informal appeal decision or for the formal appeal recommended decision of the Hearing Officer for a period of up to sixty (60) days to facilitate settlement discussions. If the parties reach a resolution as reflected by a written settlement agreement within the sixty-day period, then the stay shall be extended for such additional time as may be necessary for review and approval of the settlement agreement in accordance with § 2.2-514 of the Code of Virginia.”

As authorized by the General Assembly, DMAS will amend the regulations governing the provider appeal process to: reflect that settlement proposals may be tendered during the appeal process; describe the framework for submission of the settlement proposal; explain that the stay only affects the informal appeal decision deadline or the deadline for the recommended decision of the Hearing Officer in a formal appeal (depending on the appeal stage); and state that approval of the settlement is subject to the review of the Office of the Attorney General (and Governor, if applicable).

Pending amendment of the appeal regulations, the Department will use the following general process for the receipt of settlement proposals during the appeals process. Settlement proposals are to be submitted to the Director of the DMAS Appeals Division, who will then refer the proposal to one of the DMAS Appeal Representatives authorized by the Office of the Attorney General (“OAG”) to represent DMAS in administrative proceedings. A settlement proposal should be submitted as soon as possible after the appeal has been filed. Once the proposal is received, the Appeal Representative will contact the provider to discuss the terms of the proposed settlement. If both parties jointly agree to the stay pending negotiations, the deadline for the informal appeal decision or the formal appeal Hearing Officer’s recommended decision will be stayed for up to 60 days to facilitate settlement discussions, with the 60-day period commencing on the date that both

parties agree to the stay. The Appeal Representative will notify the Appeals Division Director that a stay has been initiated and when the stay concludes.

The Appeal Representative will communicate the terms of the proposed settlement to the DMAS Director, who will make a determination whether to reject the offer, propose a counteroffer, or request approval of the settlement (as proposed or as modified during the negotiations) from the OAG (and Governor, if applicable). If the Director of DMAS authorizes a settlement proposal to be forwarded to the OAG (and Governor, if applicable) for approval, then the stay will continue beyond the 60-day limit and until that review process is completed.

A stay might conclude for reasons including, but not limited to:

- (i) the parties are unable to reach an agreement on proposed settlement terms during the 60-day stay;
- (ii) a party no longer agrees to the 60-day stay and terminates settlement discussions; or
- (iii) the settlement agreement is not approved.

If the stay concludes, then the time period to issue the informal appeal decision or recommended decision resumes on the day the stay is removed (e.g. if a stay is jointly agreed to on the 10th day during an informal appeal, but the settlement agreement is not approved, then the informal appeals agent will have 170 days from the date that the stay is removed to issue the decision).

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanoftv.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 4.0:
<http://www.dmas.virginia.gov/#/med4>
- Commonwealth Coordinated Care Plus (CCC Plus):
<http://www.dmas.virginia.gov/#/cccplus>

- Program of All-Inclusive Care for the Elderly (PACE)
<http://www.dmas.virginia.gov/#/longtermprograms>

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: <http://www.dmas.virginia.gov/#/cccplus>

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at <https://providerportal.kepro.com/Account/Login.aspx?ReturnUrl=%2f>

HELPLINE

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is <http://www.dmas.virginia.gov/#/appealsresources> and the form can be accessed from there by clicking on, "Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to [talk to your Medicare patients](#) about the new Medicare Card. Bookmark the [New Medicare Card](#) homepage and [Provider](#) webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that is unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:

<https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html>
